So in closing, it just seems to me that people who are pushing for giveaway after giveaway, or runaway spending, and who then come in and complain about the deficit is a bit, it seems to me, like a herd of cattle standing around a lake complaining that the water does not taste all that fresh. For those of us who are fish that are trying to have clean water, it is just a little difficult to have people plopping stuff in the water that is just tough to swallow.

WTO NEGOTIATIONS ON U.S. AGRICULTURE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. OSBORNE) is recognized for 5 minutes.

Mr. OSBORNE. Mr. Speaker, at the present time we are conducting some talks, WTO negotiations, involving the European Union. I would like to call attention to some figures that I think most people are not totally aware of.

First of all, if you compare the United States economy with the European Union, the United States economy is $11.7 trillion annually and the European Union is $9.4 trillion. So they are pretty comparable. The import tariffs we have on goods coming from the European Union into the U.S. are 12 percent, and tariffs on U.S. goods going into the European Union are 30 percent.

So we have comparable economies and yet a tremendous disparity in tariffs. This led to an agricultural trade deficit of minus $6.3 billion last year, which was the biggest deficit that we had with any entity that we were trading with for agriculture.

On export subsidies, the European Union provides $3 billion and we provide $31.5 million, so they are roughly 100 to 1 on money they spend on subsidizing their exports to other countries. As far as farm subsidies per acre are concerned, the United States subsidizes agriculture at $38 per acre with the European Union at $295 an acre. So this is a tremendous discrepancy.

One other set of data I wish to point out is that we have had two cases of BSE, or mad cow disease, in the United States. The European Union has had 189,102 in the European Union in the last 10, 15 years. Yet the European Union excludes our exports of beef into the European Union, our pork, our genetically modified crops, such as corn, and also poultry. So we are really having a very difficult time with the European Union when you look at all these figures.

Currently, we are having some preliminary WTO talks where we are looking at some ways to try to fix world trade, and I want to point out a couple of things.

□ 1715

First of all, we are proposing that the United States reduce farm subsidies 60 percent, which would mean that we would drop our subsidies from $19 billion a year to roughly $17.5 billion a year, and at the same time we are proposing that the European Union reduce agricultural subsidies to 83 percent, which would be a decrease from $80 billion down to $15 billion. That is a big drop, but still the European Union would be subsidizing double what the United States does. The European Union has rejected this offer at the present time.

I think it is important that people realize what happens in the next round of WTO talks will have great implications for the next farm bill which will be written in 2007 and go into effect in 2008. We are apt to see a move toward conservation types of payments, away from traditional types of payment.

We will have to be concerned about developing countries like Brazil. Brazil has land valued at $250 to $500 an acre. They have enough rain and topsoil to produce two crops a year. Their labor is 50 cents an hour. They can pretty well bury us if we do not provide some subsidy for our agriculture.

Lastly, I would like to issue a warning. We saw what happened to our petroleum industry. We found we could buy a barrel of oil from OPEC a few years ago for $10 a barrel. We began to get more and more from OPEC. Finally, we are pretty well dependent on foreign sources of oil. We cannot afford to let this happen to our agricultural economy. Certainly changes are in order, but I think it is important we proceed cautiously because we do not lose our food supply to foreign sources, which would be even more devastating than losing our oil supply to sources abroad.

CHILDREN'S HEALTH MONTH

The SPEAKER pro tempore (Mr. KUHL of New York). Under the Speaker's announced policy of January 4, 2005, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY. Mr. Speaker, I am joined by my colleagues this evening to talk about Children's Health Month. It is very important for all families in our Nation, and certainly an issue that concerns all of us on both sides of the aisle.

While the rhetoric of the House often echoes through these walls about cuts and people being harmed, it seems to me that is the only part of the discussion that we are taking away. Little offers are made in terms of what is needed.

What we do often hear is discussions of who is paying. Should individuals pay, insurance companies be taxed more, businesses be given tax cuts, perhaps health savings accounts, association health plans, or just have the Federal Government take over? But this should not just be an issue of who is paying, for although that is important, and how much we are paying is important, really much of this comes down to what we need to have is an open discussion of what we are paying for.

According to the National Center of Health Statistics, 83 percent of children in this country under 18 years of age have excellent to very good health. That is good news.

Now 17 percent of America's children are in less than favorable health, either to mild or severe levels. We have to make sure we do all we can to help these children have a better health future and help the rest remain healthy. According to the American Academy of Pediatrics, 6.3 million uninsured children, over two-thirds of all uninsured children in America, are currently eligible either for Medicaid or for the State health insurance programs, but they are not enrolled. There are many opportunities. I know the State of Pennsylvania, where I represent the 18th Congressional District, really has very good services and insurance for children of a low income level but we need to make sure that we expand enrollment and get those kids beyond. For those who are uninsured or underinsured but beyond the level of Medicaid, there are several things that we should be looking at to make sure that they get the health care they need to maintain their health to prevent higher expenses for emergency care.

But what this means is not just more discussions on we are cutting money out of Medicaid or other aspects. Look at what has happened to the growth of Medicaid. In 1995, and this is for all ages, Medicaid spent $150 billion. We are now up to $300 billion. About half of Americans are covered by some level of Federal insurance or health care. But the system is growing, and the concern is it is growing out of control.

While we are looking at such things as how do we pay for Hurricane Katrina's outcome in this devastated gulf region, how do we take care of so many needs, is it fair to just continue to say to the American people we are going to continue to spend more without finding ways of eliminating waste and fraud and abuse?

Let me give an example. The New York Times wrote recently about an amount of some $4.4 billion in Medicaid fraud in that State. One dentist billed for over 980 procedures in one day. Clearly these were patients that were actually being seen. Another company used van rides for supposedly disabled people, billing those rides to the government. But these people when followed by a reporter clearly were not disabled. They walked around just fine. There is example after example after example.

I believe the American taxpayer wants to make sure that this waste, this fraud, this abuse is removed from the health care system. But it is not just a matter of that. When it comes to our children, we also have to make sure the system works with these programs in ways that optimize the health and outcome.

One of the things that I want to talk about today, along with the gentleman from Georgia (Mr. GINGREY), is transforming our health care system. We oftentimes use a tongue-in-cheek quote around here that says one of the definitions of insanity is doing the same thing over and over again and expecting different results. Indeed, in the health care system where so much money is used inappropriately and wastefully, we ought to have some changes.

From the Center of Health Transformation, they say we have this current health care system and we are trying to come up with some reforms within the network. We try things like so much money is going to pay for diagnoses. We ask for some procedures to be done inpatient and outpatient, all within that system. What happens is if this system does not change, it will lead to some decay. The system cannot continue to go the way it is. Anyone who owns a small business or a household cannot continue to operate the way our health care system operates. When we go into hospitals, inpatient/outpatient, you will see the latest equipment, the greatest skilled personnel, MRIs, PT scans, CT scans, but very often we also see that data is kept on patients on pieces of paper. We have 21st century health technology kept on 16th century monitors. What happens, people slip through the cracks. The wrong prescriptions are ordered. Tests that are done have to be repeated because someone cannot get them.

I was talking to one of our colleagues today and he was telling me how a sonogram was done of his wife who is pregnant, but he cannot get it from here back home to his wife because he has to carry it manually. It cannot be e-mailed. We take e-mails for granted, but doctors have to wait for papers to transfer locations.

What happens? Can we come up with some real changes to really help our children? Yes, if we switch to an intelligent health system that uses electronic prescribing, electronic medical records, real patient care management for our children rather than having a system that gets bogged down and collapses of its own expense and weight, we can come up with success for our children and no longer be mired in failure.

Let me describe a little bit about what we mean by managing the whole patient. A lot of what people think happens when they have an individual or chronic disease is something common, like diabetes or asthma in a child, the doctor will examine and make sure that the child has the right medications, watches their diet and the environment around them, and hope all goes well. As long as the parents are monitoring that carefully and there is communication between doctor, nurse, patient and child, you can have a pretty good system. What happens if the information does not get to the parents, the patient education is not quite there? Maybe they skip a prescription, maybe they did not pick it up on time, maybe they do not fully understand all the elements of diet and medications for complicated diseases. What does that mean? You can end up with chronic diseases, repeat tests, many hospitalizations, emergency care may be required, increasing medications, going from doctor to doctor who may not know the other medications the child is on, leading to further risks, and all of this costs unnecessary money, unnecessary time in hospitals, increases the risk for harm, and what happens, we end up paying for it.

About 10 percent of the cases that show up in an emergency room are someone who has no ability to pay, but it is estimated that 60 percent or more, 60 percent or more of patients who show up in emergency departments are nonemergencies. If in such cases the care was given ahead of time, whether it is through a community health center, a clinic, direct patient care with a physician, if we monitored and kept a careful eye on those children with chronic conditions, we could save massive amounts of money.

This is not cutting care, it is improving care. Emergency care can cost five to eight times more than outpatient care, and we can actually save billions of dollars in the system. This is where we can find savings, and in so doing we save lives as well as money. But this means we use a chronic care model and not the inefficient going to a doctor, another disease, go to another doctor.

What this involves is not just the health system, it really involves the community, the resources. What takes place, the support systems, the families, the individuals helping to make sure they are watching their children, they are educated and they know what to do. It is making sure we have a delivery system involved with making sure doctors are notified if someone does not pick up their prescriptions. A lot of this can be done with electronic prescribing notification. It is making sure that clinical information systems are there so that if X-rays are done, procedures and tests are done, that information is communicated back to the doctor.

One study I looked at said something like 14 percent of the charts reviewed the physician found that they were missing some important data. Perhaps the physician referred the patient on to have some testing done, and it was never done. In the majority of these cases, the doctor said it would affect what diagnosis they had and future tests called for.

This is not a matter of just saying we are going to cut care, this is improving care. But this also means that clinical information systems must be there. They are a critical component of health care, of having the physician and nurse and family work together. What does that do? It is a matter of having productive interaction between everybody involved. You have an informed, active patient and you have a prepared, proactive practice team.

No longer the passive system, the doctor says here is your diagnosis, here is your prescription, good luck, call me if there is a problem. If that prescription is not filled, there is a call from the doctor. It is a system of interaction between the patient and doctor to make sure they are going back and forth.

Mr. Speaker, I am not talking about things that take place only in families that have access to computers and finances to do this. A lot of this is done in areas of low income levels, of high risk populations where we really find it is much more affordable. What we need to be looking at here as Congress is when we are reviewing such things as the Medicaid system, it is not just saying we are going to lop off $8 billion or $10 billion and see what happens. It is a matter of doing more effective work.

Much like a household that says our spending is going out of control, they do not just say let us not spend any more. Every small business and family does this. They look at what they are spending, but you have to change some of your habits and make habits more effective.

The system that seems to be adapting the slowest is our health care system, perhaps because we just keep doing the same thing over and over again and expecting different results.

What the Federal Government is going to do and what we are doing here in the Republican Conference is asking those questions and demanding some answers of changing some of that system.

What I would like to do is call upon the gentleman from Georgia (Mr. GINGREY), who as an obstetrician has worked with many families, particularly in the area of prenatal care. One of the critical areas in cutting costs and being more effective in health care is dealing with prenatal care in an effective and positive way.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. GINGREY) to talk about these aspects of prenatal care, and he can tell us about some of the elements of saving money by doing more effective patient care management.

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Pennsylvania (Mr. MURPHY) for leading this hour during this week of Children's Health Care Initiative and calling attention to the health of our children. The gentleman from Pennsylvania (Mr. MURPHY) has worked extensively in the field of psychology, particularly child psychology. He has actually written a book and has another coming out soon on the subject. I think as we get further into the hour, we probably will discuss a little about bit about how important a child's not only physical health but their mental health is.

□ 1730

But I do appreciate the opportunity that the gentleman has given me, Mr.

Speaker, to share some of this time with him.

My background in a prior life, my professional experience was for 30 years in the practice of medicine, and the specialty that I enjoyed practicing was obstetrics and gynecology; and we have that opportunity in that field of medicine to see a child at the very beginnings of life and know how critically important a good start is. We talk about some of the things that this Republican majority has done, some of the very good programs since President Bush has been in office, certainly not the least of which is No Child Left Behind regarding our K–12 education program. But it is so important from the health care perspective that no child is left behind from the moment of conception.

So I do want to talk a little bit about the importance of prenatal care and actually call my colleagues' attention to this one poster that I have here regarding prenatal care, entitled ''Proper Prenatal Care Leads to Healthy Children.'' No question about it. Some of the bullet points, these may be a little bit difficult to see, Mr. Speaker, but hopefully we can focus the camera in on the bullet points.

First of all, 1 million, 1 million, American women deliver babies annually without receiving prenatal care. Secondly, in the United States, more than 250,000 low birth weight infants are born each year. More than 250,000. Now, for my colleagues' understanding, a low birth weight infant is one that weighs less than 2,500 grams. That is about 5½ pounds. Those children are not all premature. In some instances they are unhealthy children who are near term, but low birth weight. But most of them, most of these 250,000 low birth weight infants are actually born premature as well.

And the third bullet point, low birth weight infants are more likely to suffer from disabilities, things like heart defects and respiratory illnesses. They are four times more likely to prematurely die than infants with a normal birth weight.

I have had many situations, Mr. Speaker, as an obstetrician having delivered over 5,000 children, where women come into the emergency room having had no prenatal care. And they are clearly the ones who are more likely to deliver these low birth weight babies and deliver them prematurely. That is why I think it is so important, and I know the gentleman from Pennsylvania (Mr. MURPHY) would agree with me, that when we emphasize the issue, the immigration issue, of securing our borders and want to make sure that every immigrant that comes into this country comes here legally and has an opportunity to get prenatal care, as, of course, many of those who come in an illegal manner are afraid or do not now how or where to get prenatal care and will just show up in the emergency room having delivered an unhealthy premature low birth weight infant, the cost of taking care of a child in that situation in the very expensive setting of an intensive care nursery, a 2-month stay, and that would not be uncommon for a very small infant, could approach easily $750,000 to $1 million worth of health care. And that, Mr. Speaker, is really just the beginning.

That is just the beginning of the cost, because if there is a disability that is long lasting or maybe even lasting a lifetime, and that is often the case, whether it is a heart defect or a musculoskeletal deformity or a mental defect as a result of lack of oxygen, sometimes even blindness, the cost is just astronomical. So it is so important, it is so important, that we do things in this Congress at the Federal level to encourage that women get prenatal care and that children are born healthy and that, indeed, no infant, not just no child left behind, but no infant is left behind.

So I just wanted to go over with my colleagues some of the things in regard to prenatal care that are so important that I always stress to my patients: of course, encouraging immunizations and vitamin supplements, monitoring of diet, increased physical activity, clearly to avoid smoking and alcohol use during pregnancy and drug use. Certainly any drug use that is nonprescription or not under the jurisdiction and guidance of a physician is to be discouraged. Environmental factors are hugely important. As I say, a healthy diet, a regular weight check, physical activity, all of these things are so important. And then to come see the physician on a regular basis during the pregnancy. This is how we avoid, Mr. Speaker, these 1 million American women delivering babies annually either without receiving prenatal care or ending up with premature deliveries.

I want to, if the gentleman would allow me, to expand on this a bit. It is not just being born healthy and well; but the first 5 years of life, what happens to the child after that is tremendously important as well. I have a grandson, little Grey Collins. He will be a year old soon. And it is so much fun to see him, and I often have that opportunity to see him, watching the little Baby Einstein tapes, that he is hugged many times a day and loved by his parents and grandparents and his aunts and uncles and how important it is to provide that love and affection to a child and let them know that they are loved, and we will get into that. I am sure the gentleman from Pennsylvania (Mr. MURPHY) will talk about that later in the hour as he discusses things like childhood obesity and childhood mental health.

But I wanted to speak a little bit about a program that we just reauthorized in the last couple of weeks here in this 109th Congress, and what I am talking about is the Head Start program. Sometimes we get criticized, we, the Republican majority, that we do not care enough about social programs and we do not care enough about the poor and underprivileged and people that do not maybe have the same opportunity that the upper middle class society has.

But let me tell the Members we do care. We do care. And this reauthorization is proof of the pudding.

Just a little historical perspective on that. Head Start and its cousin, Early Head Start or comprehensive child development programs, serving children from birth to age 5, as I stated, as well as pregnant women and their families, the critical component of the Head Start program is that it is child focused with the overall goal to increase school readiness of young children in low-income families, Mr. Speaker. The Head Start program has a long tradition of delivering comprehensive and high-quality services designed to foster healthy development in children that need our help the most.

The program provides a range of individualized services in areas of education, early childhood development, but not stopping there. It also offers medical, dental, and mental health services to these children and to their families. It even goes a step further by providing nutritional counseling and encouraging parental involvement in their child's development. It is a rich program. I have got a lot of statistics, and as we continue the hour, I will relate some of those specifics, particularly in regard to the reauthorization and how much we are doing in that program.

But I just wanted to point out, as I know the gentleman from Pennsylvania (Mr. MURPHY) agrees, how important it is that we do everything we can to make sure that our children get a good start in life. And as I have stated at the outset, the prenatal care aspect is hugely important. Programs like the Early Head Start and Head Start program so that the children, all children, when they get to that 5-year-old kindergarten class or get to the first grade, that they have an equal opportunity with their peers and they are not starting school with one hand tied behind their back. So it is hugely important that they are healthy, that they are happy, that they are loved and they have an opportunity, as we all want, in life.

At this point I will continue to be here with the gentleman from Pennsylvania (Mr. MURPHY) during this hour.

Mr. MURPHY. Mr. Speaker, reclaiming my time, I thank the gentleman for his learned information for our colleagues to be aware of not only Head Start but about prenatal care.

One program I want to mention, the National Nurse-Family Partnership, is a great example of success. It is a public-private nonprofit center. I believe it is centered in Colorado, with over 700 nurses delivering in-home prenatal care and early infant care to more than 13,000 low-income families throughout the Nation. Interestingly enough, they were able to demonstrate they could

return $4 savings for every $1 invested in these services by the time the children reach age 15 by reducing expenditures for such things as special education, emergency room visits. Again, when we use a more comprehensive patient care model, we look at the whole family and not just the individual disease, we can save money and provide care.

Secondly, I also applaud my colleague for bringing up those aspects about Head Start and Early Head Start, so critically important for families who are struggling to make ends meet to have this system that really puts the parent at the center of the child's care, making sure they are involved in all the decisions, making sure they have the information they need to have, making sure that they are, in essence, put into the role of parent and not government in the role of parent; and that makes all the difference in the world.

Let me shift into another area here, however, that is also critically important and something we dealt with today. At any point if my colleague has comments he wants to make, I certainly would encourage him to do so. But this is the area of childhood obesity. Today, we passed a bill out of the House that said that we cannot just be blaming restaurants and fast-food companies and food manufacturers when someone has obesity problems. Indeed, it is something we all have to work on and have responsibility for because whether they are healthy snacks that a person eats too much of or unhealthy snacks, whatever that is, we have to make sure that we watch our diet and have proper exercise.

Unfortunately, what has happened in this Nation, I believe it may only be the State of Illinois that still requires gym class in school, and as such, children spend much more sedentary time at home, playing video games or in front of the television, less active, and eating more during that time. This is a major contributor to childhood obesity. And what has happened in the last 10 years, and look here, the proportion of obese children has tripled since 1970. It has doubled in the last 10 years, tripled among teenagers actually during this time period, and increased incidences of disease associated with that, including such things as now we see adult onset diabetes showing up in our children. We also see heart problems showing up. We see the risks that take place with blood pressures that are showing up in children who really did not have these problems before.

This is an estimated annual cost of obesity-related diseases in the United States: $100 billion. $100 billion annual cost of obesity-related diseases. This is not something that is cured by simply having government come in and tell people what they can and cannot eat. Something has broken down in our families and our communities where we are no longer telling kids they have had enough to eat or they are not going to eat any more of that or they need to get out and play.

The annual hospital costs for obesity-related disorders in children ages 6 to 17 years of age increased from $35 million to $127 million between 1979 and 2000. It is a lack of physical exercise; 38.6 percent of United States adults report they have no leisure-time physical activity at all. The annual estimated cost for diseases associated with this physical activity in 2000 was $76 million, but we know that daily participation in physical ed classes by high school students has dropped from 42 percent in 1991 to 29 percent in 1999 and continues to decline.

□ 1745

Even though we have data that continues to tell us physical exercise is critical and important, not just for a child's physical health, but really, as we are looking at ways of managing this, we cannot continue to just pump money into the Medicaid system and into our insurance systems to cover the costs of the outcome at the end of the line.

We need to go upstream and work on some basic prevention, and that means, quite frankly, mothers and fathers across America have to work on these issues of teaching their children to be responsible for their own bodies, making sure that we, as Members of Congress, are talking about these issues, but making sure as we monitor how money is spent we are much better off looking at ways that funding could be given to communities, programs, to schools, to hospitals to help make sure we are working on prevention of obesity rather than paying the high costs at the end of the line for so much of the increases in health care because obesity has continued to climb.

Now, with obesity often comes behavioral disorders as a matter of fact. Many a child I saw in my clinical practice as a psychologist oftentimes came in a child who was well overweight, teased by their peers, struggled with this on top of their other physical problems. They oftentimes got in this downward spiral, less activity, more socially isolated. Perhaps they were teased by other kids, the butt of jokes, a sad condition, and many of these children also suffered problems with mental health.

What happens in the area of mental health is sometimes in this Chamber and our Nation, we look down upon it from a couple of different angles. We see perhaps mental health problems are some sign of softness, that perhaps people should be a little tougher, take it on the chin, not be so sensitive. Sometimes I am not sure we have advanced from the days of the Salem witch trials, and blame those who suffer from mental illness and say somehow you should have done more.

Sometimes we ridicule those who are on medication. Jokes still abound on television calling people crazy, loony, out of control, retarded, in derogatory terms, for something that we continue to see in this Nation as a sign of weakness instead of a real disease.

Again, if we are going to deal with things in the health care area, to truly reduce costs and deal with patients, we have to understand in the area of children's mental health psychological disorders are real. They are not made up. They are not indications where someone is weaker and ineffective.

There is a very strong and consistent scientific basis to say that the myth of psychological disorders and psychiatric disorders has to be debunked. Kids do have real problems. Adolescents have more problems. Adults have even more problems, and all these grow when we do not deal with these problems at an early level.

There are biological and environmental causes. It is interesting, you can have some children face tremendous difficulties in their life and they do not seem to show problems in mental outcomes, but that does not mean that those who do have problems are simply weak. Just like some of us may be exposed to the flu, some of us may eat different, and be around those who smoke and never develop any symptoms at all, where others are susceptible to them as part of their own biological genetic makeup.

Again, it does not mean they are weak or ineffective. It means a combination of the biological and environmental factors that caused this. You cannot simply say if we take care of these environmental causes it will never occur. Sometimes people say, well, maybe it is poverty that causes some of these difficulties with mental illness, and that is not the case at all. Depression, bipolar disorders, attention disorders, anxiety disorders occur at all lines of children. Boys sometimes have more than others, but there is this link between biological and environmental causes. Boys have more problems, for example, with attention disorders. Girls may have different symptoms with depression, but in all cases we also see there is a commonality between parents and grandparents having some of these diagnoses that I mentioned for anxiety, bipolar disorder, attention disorder, depression and their children. Not always children, but certainly some where you have significant environmental stresses and reactions which interact.

We may see, for example, as the outcome of the hurricanes in the gulf coast that there will be some children who live through tremendous trauma, and they may have some post-traumatic stress reactions, but it may never reach the level of post-traumatic stress disorder. It becomes a longer term debilitating factor, exhibited, for example, as such things as depression, trouble concentrating, nightmares, et cetera. It may never reach that level because they may in their own biological factors have resilience, but their family may be there to support.

The other things here is to understand that psychological disorders do

respond to treatment. This may be pharmaceutical; that is, medication, and it certainly is also matters of counseling and therapy. This is not just a matter of talking to someone, giving common-sense ideas. This is a matter of very strategic, scientifically based things such as cognitive behavioral therapy to work with patients.

We know, for example, that children with depression respond fairly well, pretty well, to some of the talk therapy or counseling to help them understand strategies to deal with problems in their life, recognize the symptoms and do their own intervention themselves to change those symptoms.

But we also know when people move from moderate to more severe levels of depression, medication, it is pretty darn helpful and sometimes almost necessary for them to have that. It does not help when we have movie stars out there saying there is no such thing as mental illness, an irresponsible statement. It does not make things go away just because you wish it to be so. I do not want situations put upon our country where we see that, again, people from Hollywood are saying, well, there is no such thing as mental illness, and therefore, we do not treat it. That is wrong. We do know that they can respond to treatment, and it is important we continue to fund in areas of Medicaid and everywhere else, Medicare, psychological, psychiatric treatment because it is helpful.

We also need to, however, carefully evaluate the treatment, the planning and follow-up assessment of these. I will give you a couple of examples.

Last year, there was a lot of discussion about some anti-depressant medication, and when some children took it, there was a higher risk for suicidal thinking, suicidal ideations we call it. What did not come up in those discussions are a couple of important factors. One, 75 percent of psychiatric medications are prescribed by nonpsychiatrists. They may be highly qualified physicians. In many cases, they may be general practitioners, pediatricians, family doctors, obstetricians. Seventy-five percent, however, and they may or may not be doing the other follow-up that is necessary.

What anti-depressant medications do is they can change a person's mood. They can help change the chemical, biological reaction that a person's central nervous system and brain of how they process stresses that can lead to the debilitation of depression, but it does not change the way a person thinks. That is why it is so important that we make sure we are funding programs that also provide the psychological therapy for children to help them understand what these thoughts are, to help them change the way they are thinking about the world so as they start to feel better they do not have more suicidal risks.

Interestingly enough, one of the things we oftentimes taught medical students in medical schools is once patients start getting better with symptoms of depression, the risk for suicide may increase because the support systems back off and they say Johnny's feeling better, we do not need to have him in the hospital or do not need to be around him as much. Perhaps people are no longer monitoring the person 24 hours a day. They start to go back to school, face more stresses.

As they are getting their energy up, as they are back in the world and thinking if we do not change the way they think with depressive thought patterns, if we do not interrupt that and change it, you can actually increase the risk for suicide. That being the case, we have to make sure that as we are looking for more effective ways of spending money, the taxpayer dollars in Medicaid and Medicare and Head Start that we are working comprehensive care with the patient, with mental illness as well, such problems as I said before about bipolar; that is, manic depressive illness, attention deficit disorder, anxiety disorders, all of these with a strong genetic component and elements where we can make huge changes in people's lives.

It is something that we need to make sure we are no longer just criticizing about overprescribing or perhaps saying that too many kids are getting stimulant medication with attention disorder; we should or should not do this.

Here is the crux of this. It really is a matter of having accurate diagnosis and treatment and making sure that we are not overmedicating or undermedicating our children. Somehow in this Chamber we politicize this to somehow think we are doing something wrong in both areas of the conservative far right, the liberal far left, somehow accuse maybe there is some conspiracies involved in this, and there is not. It is a matter of making sure the physicians have the training to deal with this. They are interacting a comprehensive care model, a patient care model, disease management model, together with people of various professions and working closely with the families.

We see this in the area of children's health when you start to look at so many aspects here that you really can make some huge differences.

I would like to point to a couple of things here and then call upon the gentleman from Georgia (Mr. GINGREY), my colleague, on a couple of questions. But one of the things to keep in mind about depression, which is one of the most common mental illnesses affecting more than 19 million Americans each year, that it can cause longer lasting forms. You can lose pleasure in life, complicate other medical conditions, can lead to suicide, but it is also associated with many other medical issues.

For example, cancer has a higher incidence of depression, stroke. Diabetes, people with diabetes have a 25 percent chance of having depression. That is higher than the rest of the population. Depression also affects as many as 70 percent of patients with chronic diabetic complications. People with heart disease, 40 to 65 percent of them will have depression, and what is interesting is untreated depression in these patients can lead to complications, such as the health care costs can double.

Now, I ask the gentleman from Georgia (Mr. GINGREY) on this, he certainly treated many a patient who had medical complications as well as some of the psychological ones, and I would like to ask him, in looking at some of these more comprehensive chronic care models, of how we need to be moving forward in a modern system of health care and not be just looking at individual disease, but how looking at more advanced forms of bringing technology and changing the system, how he sees that affecting the patient in a cost-effective way.

Mr. GINGREY. Mr. Speaker, as the gentleman pointed out, and he is so right, we need to move into the 21st century in regard to our health care system and modeling. Just trying to come up with better drugs and the latest surgery techniques to treat complicated illness is not enough. We really need to focus on preventive care.

You are talking about in the last few minutes, of course, your specialty, in talking about mental illness, and as it relates also to childhood obesity, and I could not help but think as I was listening to your discussion, and as you know, this week we just passed H.R. 554. H.R. 554 is the Personal Responsibility in Food Consumption Act of 2005. This is a bill my colleagues are aware of the fact it would not allow someone to sue a fast food manufacturer because they have gorged themselves with a multiple number of Big Macs or any other kind of fast food, or sometimes what we refer to as junk food. It is not the fault of the food industry.

I used a little analogy when I was talking about this on the floor yesterday in discussing the rule of my belt, which is a size 36. That is, I hate to admit, the size of my waist, but if I wanted really out of blind pride to suggest that I had a 24-inch waist and I cinched that belt down a couple of notches, in doing so, I put pressure, compression on something referred to as the lateral femoral cutaneous nerve, it would result in a condition of numbness and lack of feeling on the anterior thigh. Then should I go out and sue the belt company because they are at fault because I misused a product?

This is what this bill, of course, is all about, a common-sense type bill.

Parenthetically, Mr. Speaker, I also want to mention the gentleman from Florida (Mr. KELLER), the author of the bill, our good friend and colleague, is actually in the hospital now and recovering hopefully from a fairly minor condition, but we want to pay tribute to him. I know he is proud that we passed this bill this week.

The comment that I wanted to make is this issue of personal responsibility, and parents should have that personal responsibility obviously in the way they conduct themselves in regard to how they eat and a healthy diet and exercise, but even more importantly is the responsibility that they have to give a good example and instruction to their children.

I think it is probably the worst form of child abuse to let these youngsters that at a very early age overeat and become obese. You have talked about the issue of poor mental image, self-image, and of course, I also see you talked about Hollywood and, of course, this issue of there is no such thing as mental illness. I think probably they might predominate in some of those diseases, which we categorize as mental illness.

But quite honestly, when a child goes to school and there is this emphasis on thinness and you see these youngsters wearing these Britney Spears' jeans and that sort of thing, a child even a little bit overweight and certainly one that is significantly obese, of course they are going to have a poor image of themselves. They are going to withdraw, and they are going to become shy. It is very likely they are going to be picked on. How in the world can they grow and develop with a healthy self-image? No wonder they end up needing to be counseled and treated by the gentleman from Pennsylvania (Mr. MURPHY) and other mental health care specialists.

Yes, unfortunately, some even go on to harm themselves and possibly even commit suicide. So I guess the most important thing that I would want to say as a physician Member is that we need to prevent this.

□ 1800

We need to make sure that parents get the message that they have an obligation, not just to take care of themselves, but first and foremost to take care of these precious children that they bring into the world. It is their responsibility to make sure that they are from the very beginning, when they start eating at the table, to make sure that they are healthy and stay healthy so you do not have to have them ending up in your office treating them for not only mental illness but also the many complications of obesity.

You mentioned them. You mentioned diabetes, high blood pressure, so many things. And talk about the cost to this health care system of ours. We always talk about waste, fraud, and abuse in the Medicare and the Medicaid programs and wanting to eliminate that, and we are very diligent and will continue to be so. But this is almost a no-brainer. It is like we heard former Speaker Newt Gingrich say to a group of us earlier today, and the gentleman from Pennsylvania was a part of that as we had him come to speak to Members of the House. We are not talking about low-hanging fruit here in regard to saving money and saving lives. We are talking about fruit that is lying on the ground sitting there rotting waiting for us to pick it up. So clearly that is what my message would be in regard to that.

Mr. MURPHY. I thank the gentleman. I asked about another issue, too, which is one that is so critically important for children. My colleague from Georgia had mentioned before, during pregnancy, smoking being one of the risk factors. I believe that the sad statistic is that the Pittsburgh region has some of the highest maternal smoking rates during pregnancy in the Nation. My understanding is a lot of complications can come when you have a mother who smokes during pregnancy. Certainly an important part of prenatal care for our children is understanding the importance of helping a mother to stop smoking during that time.

I wonder if the gentleman can comment on some of the complications that might come for that mother and that baby not only during labor and delivery but the long-term effects for that child when the mother smokes during pregnancy.

Mr. GINGREY. Without question probably the most common condition that we see in smoking moms is something called toxemia of pregnancy. Toxemia, by the very word, it is a poison. We do not know exactly what that poison is, but something occurs in those moms that develop toxemia. It is not always because of smoking, but frequently it is. And also so often that condition will lead also to pre-term labor and delivery and one of these low birth weight infants.

In the extreme, toxemia of pregnancy before birth results in a very, very high blood pressure. It can cause a stroke, a deep coma, one from which sometimes the mother never recovers and the child is lost. So we are talking about one of the worst complications of pregnancy other than just out and out exsanguination from bleeding, which is also a possibility in any pregnancy.

But smoking, we see that condition more often. And then, of course, childhood asthma, which I am sure the gentleman has seen plenty of cases of that, youngsters that come in because there is that secondary smoke situation. Not only do they have to suffer with it during the 9 months of pregnancy of their mom; but once they are born, that smoking continues in the household. So it is a huge complication, no question about that.

Mr. MURPHY. Also, it is related to, my understanding is yet so many other aspects come from this that you may find in such children also eating disorders and diabetes and cancer risks even if that child never themselves smoked cigarettes. But the risks are huge. I believe a direct and indirect medical cost of smoking in this Nation is about $138 billion per year.

Of course, another reason why I believe it is so important not only for the government but really for individuals and businesses to focus so much on helping to change that is the State of California, for example, estimates that their statewide tobacco prevention program during the 1990s resulted in overall cost savings of $8.4 billion in health care. That is pretty remarkable.

Again, unfortunately, the way the Congress scores things with the Congressional Budget Office, when we talk about starting programs that would actually save money, my colleagues are aware of this, we never can get an accurate measure of what it actually saved because of the way the CBO, the Congressional Budget Office, scores things. It is not how much you save, but how much you spend. So if we would do similar things that would lead to a smoking cessation during pregnancy, and it might cost X number of dollars, the CBO would score that but never tell us how much money it would save over time. That is something that frustrates all of us because the things we are talking here tonight really require some expenditures to get these savings.

Businesses are picking up on this. A recent review of health promotion and disease and management programs in businesses that provided health education to their employees, including exercise, health-risk screening, weight control, nutrition information, stress management, disease screening, and smoking cessation, found a significant return in investment, saved about $1.50 to about $5 for every dollar spent in the program.

For example, Motorola, their wellness program saved the company about $4 for every dollar invested. Northeast Utilities' program in its first 24 months reduced some of the claims by about $1.4 billion. Caterpillar Company, they had a program that saved about $700 million. Johnson and Johnson's health and wellness program saved about a couple hundred dollars per employee per year.

What is interesting here is how much we can save and what we have to look at here. And I call upon my colleagues, we need to make some fundamental changes in how CBO scores these things. We have got to stop just looking at how much it costs up front and look at how much it saves in the long run. Again, I look at such things as if we are able to have more people go to federally approved health centers, community health centers in their community instead of showing up in the emergency departments, yes, it may cost money; the President called for a couple billion dollars to put into those community health centers. But if it is one-fifth of the cost of going there rather than the cost of going to the emergency departments, that is a massive cost savings.

Certainly I call upon my colleague, too, it is one of those things you have seen as well, how do we get these prevention issues begin to be scored. It is of fundamental importance to health care.

Mr. GINGREY. The gentleman is so right, and I appreciate the opportunity to weigh in on this issue.

This issue of scoring, as the gentleman is talking about, it reminds me of course of the debate during the Medicare Modernization and Prescription Drug Act that we passed in December of 2003. Of course, that part D will go into effect and the modernization piece is already in effect for Medicare, but part D, the prescription drug part, will start January 1. But all we heard and continue to hear, particularly from the other side and for those nay-sayers who keep wanting to talk negative about really a very good program that is going to be a Godsend for our neediest seniors, I talked about this on the floor, my colleagues I know heard me last night. But the talk, the emphasis is on the cost of part D, and the cost estimate is based on the number of seniors that participate ultimately.

I do not think anybody really knows, Mr. Speaker, what that number will be; but at one point it looked like the CBO said, well, it is going to be $400 billion additional Medicare cost over a 5-year period of time. Then those numbers were revised, and then we were hearing as much maybe as $750 billion. That is the scoring that the gentleman from Pennsylvania is talking about, and my colleagues understand what he means. You get no credit for the fact that many people who sign up and, yes, there will be an additional Medicare cost for them on this part D program, but the fact that they are able to take those medications, they can finally afford to take that statin to lower their cholesterol and that medication, that insulin to lower their blood sugar or whatever antihypertensive to lower their blood pressure, guess what, we get less spending on part A, the hospital part, when you end up in the emergency room with a stroke because you could not take your medicine, or you end up on the operating table for your coronary bypass or maybe even worse an amputation or a kidney transplant, and then you have this huge cost to the physician under part B.

The truth of the matter is, and what the gentleman was emphasizing, is that you get no credit for saving those costs, not to mention the fact that it is so much more compassionate to spend money on prevention rather than treatment, particularly when the treatment sometimes is not very successful and a person could ultimately be in a nursing home for years and disabled for the rest of their lives.

I will take it a step further before turning it back over to my colleague. It is the same thing, this scoring issue, in regard to the tax cuts that this Republican leadership has effected over these past 3 years. The scorers, the CBO, the number crunchers say, well, these tax cuts, the elimination of the marriage tax penalty, increasing the child tax credit from $600 an infant to $1,000 a child, giving small business men and women an opportunity to more rapidly depreciate investment in bricks and mortar and creating new jobs, all of these things, elimination of the death tax, no taxation without respiration I firmly believe in, the scorers said that was going to cost us $1.3 trillion.

My colleague remembers that. And a lot of people said, oh, we cannot afford that. What are we doing cutting taxes? Well, after about a year and a half, when we looked at our revenue stream, what was the result? We had about 225 billion more dollars, which on the scoring side we get no credit for.

So the gentleman is so right. So many of these things that we are talking about tonight in this hour, these innovations, these community health centers that the President has funded, recommended, and feels so strongly about, on the scoring side you get no credit for; but we do save money, as the gentleman points out. And just think, also, it is the compassionate, conservative thing to do for the American people.

Mr. MURPHY. I am reminded of the story of the fellow who was on his hands and knees late at night under a streetlight in the city, probably had too much to drink, and a police officer sees him and says: Excuse me, sir, what are you doing? The gentleman says: I am looking for my car keys. And the police officer says to him: Well, where did you lose them? He said: I lost them down at the end of that dark ally down there. And the policeman says: Well, why are you not looking for your keys at the end of that dark ally over there? And the gentleman says: Because there is more light over here.

Sometimes I think the way we look at these medical issues, instead of looking at the cost savings involved with prevention, we simply are able to look at how much it costs us up front because it is easier to find that data. It is tougher to pay attention to prevention.

My colleague brought up some great points. Prenatal care, Early Head Start, Head Start, what that contributes to in helping save problems. We talked about community health centers and spending money. I like the President's plan of a community health center in every county in America where there is poverty and an uninsured, can help reduce emergency visits by four-fifths, the cost of the emergency visits. It is an incredible amount of savings, but not one that we can get those scores for. And it is one of those things where, unfortunately, the political rhetoric comes through in this Chamber, and I do not know of anybody who has ever been cured by a floor speech, but it certainly is one where there is just so much talk that continues on, spending too much here, spending too much there. We need to pay attention to spending too much.

The problem is not what we are spending, but what we are spending it on. And if we are continuing to spend on wasteful or fraudulent or abusive or simply health care issues that are not taking care of the disparity of outcomes between, for example, low socioeconomic families, families that are struggling to make ends meet and feel they do not have the money to pay for their doctor visits, and those that may be in poverty, we need to work on those disparities of outcomes and make sure that we take care of those children early on; and that is why the issue of community health centers for our kids is so critically important. But, again, some will say we are spending too much, causing the budget to go up, and we cannot get the proper numbers.

Now, some of the public that may be listening is wondering why we are even talking about the CBO. But that is, unfortunately, the way this Chamber operates now and that people oftentimes look at those numbers. We have seen tremendous inaccuracies in those numbers. My colleague from Georgia spoke about those inaccuracies when it came to looking at things such as the death tax and them being off over $1 trillion in their estimates. But also it is one of those things in health care, too.

Think about this: if you take a medication that costs you $50, but it may prevent you from having a heart attack and further hospitalizations, surgery, disability, workers comp, losing your job, having the family require other care, that is a massive amount of cost savings. But, instead, we may focus on only that aspect of the cost of that medication, instead of all the other costs that are saved there. When we look at what we are doing with children's health, it is so critically important that we look at the big picture here as well.

Now, I am going to see if my colleague has any final comments to make in this area of health care. Barring that, I just want to mention a couple of final comments here.

□ 1815

We are certainly the stewards of the people's money, and although we are not here to take the place of the family, we are here to do sometimes what Abe Lincoln said. President Lincoln said, ''Governments should do that which the people cannot do for themselves.''

Now, in the areas of such things as food and consumption, people and parents ought to be watching what they eat. Well, what we also ought to be doing ourselves is working along with physicians and schoolteachers and people in the community to make sure our kids are healthy and safe and exercise and eat right.

But we also have to make sure we are working at comprehensive care, real patient care models, that involves nutrition and exercise and prevention and mental health, and integrated care of all of those things together. If we are

truly going to do what is right and decent and honorable for the next generation, it is a matter of doing what is right in health care.

It is a matter of pooling our resources together and looking at the answers, to be science-based and not emotion-based on this. The science tells us we have things we can do, but we are not yet doing. The science tells us when it comes to managing the disease it is not appropriate to just look at that individual disease, but to see how it operates in the context of the child and their family.

This is true compassion. This is where we will save lives. This is where we will save money. This is where if we do things like looking at electronic medical records, and make sure that every hospital around the Nation has this, and providers and pharmacists have these, you can find out these things and work on them together.

That is what takes place in States like Nebraska and other hospitals around the Nation. We have here an opportunity to make a huge difference, to save lives by the hundreds of thousands, and to save money by the hundreds of billions of dollars. We have that opportunity before us.

The question is, will we have the courage to work together in a bipartisan manner to do it? My hope is that our colleagues drop the gloves on this, put down the swords, stop looking for opportunities to send out sound bytes and to have people make phone calls and use it as political fodder, but instead to be able to look our constituents in the eye and say when we were all here, when we were all granted the authority to do something about America, we took an opportunity to save lives and save money, and we ought to start with our children.

I thank my colleagues.

DEMOCRATIC ALTERNATIVE TO CUTTING THE BUDGET

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from South Carolina (Mr. SPRATT) is recognized for 60 minutes as the designee of the minority leader.

Mr. SPRATT. Madam Speaker, as we gather here tonight to talk over the problems of the budget, our colleagues on this side of the aisle, the Republicans, are locked in a dispute over how to pay for Hurricane Katrina, the cost of which could fall between $100 and $200 billion, maybe even more, for the Federal Government alone.

Some, for the most part their most conservative Members, have proposed big cuts in programs that range from student loans, to Medicaid, to food stamps, about $50 billion in spending cuts spread over 5 years.

They present these spending cuts as a way to offset, partially at least, offset the spending increases that the response to Katrina and Rita are going to require. But in actuality these spending cuts will not go to offset Katrina, because the Republican budget, the budget resolution operative for the year 2006, the resolution to be brought to the floor to be amended, already calls for $106 billion in additional tax cuts, $106 billion in new tax cuts.

And when these new tax cuts are passed, the spending cuts proposed, ostensibly to offset the cost of Katrina, will instead go to make up for the loss of revenues due to the $106 billion in tax cuts. Since the spending cuts are $50 billion and the tax cuts are $106 billion, none of the spending cuts will ever make it to the bottom line where they might otherwise be available to offset the cost of Katrina.

So the first problem that we as Democrats have with what our Republican colleagues are pushing is that it is not what it purports to be. It is not a plan to pay for Katrina. It is a plan to facilitate $106 billion in additional tax cuts.

The second problem that we as Democrats have with their plan is that we believe the cost of helping one State sustain the catastrophic loss and cost of a natural disaster, a disaster like Katrina, Hurricane Rita, should be borne by all of us, by all of the States, should be a matter of shared sacrifice, has been in the past should be in future, it works and it is right.

But we do not believe that those least able to bear the costs should be saddled with the lion's share of the load. And yet that is exactly what their plan will do, because they are pushing a plan that will pay for the cost of Katrina by coming down hard and heavy on the backs of students borrowing to pay for their college education, on the sick whose only access to care is through Medicaid, and on the very poor who depend upon food stamps to feed their families.

This is just some of those on whom the cuts they are proposing will fall, and the reason we are proposing alternatives and opposing the plan that they are bringing to the House floor. What we have coming before the House is a plan for spending cuts that basically and simply does not achieve its stated purpose, because it does not go to cover the cost of Hurricane Katrina, and the spending cuts it does select, whether they are used to offset tax cuts or offset the costs of Katrina, as I have said, come down on some of these who are the least able to sustain and bear them.

It is fair to ask, I think, as we begin to consider such a program, why is it we are insisting upon offsets for rebuilding Biloxi or Bay St. Louis or New Orleans, but not insisting on offsets to pay for rebuilding Baghdad or Mosul or Basra.

Well, one of the reasons I believe that we are experiencing this newfound interest in offsets that might diminish the deficit is that the evidence of a swelling deficit that is not going away, it is a structural deficit, built into the budget, not a cyclical deficit deficit based on the ups and downs of the economy, one that is going to be with us for a long time to come because of fiscal decisions that were made in 2001, 2002, 2003 and 2004, is becoming so obvious, so widespread, so obvious, so significant that it simply cannot be denied.

I mean, after all the basics are apparent and they are well known. As Yogi Berra used to love to say, you can look it up, it is a matter of record. Back in the year 2000, we had a surplus of $236 billion. Matter of record. The budget was in the black by $236 billion, unprecedented. That was a budget that was inherited by Mr. Bush.

Today, just a few weeks ago as a matter of fact, the administration closed the books on fiscal year 2005, and when they closed the books they finally declared the balance at $320 billion. And they took some credit because that deficit is actually smaller than the deficit in 2004, which was $412 billion. But a $320 billion deficit is nothing to crow about.

Look at what has happened over the last four fiscal years. The simplest way to show it to you on the back of an envelope is to look at how many times our Republican colleagues have had to vote to increase the debt ceiling of the United States, and what those total increases come to since 2002.

This chart shows it to you very, very clearly. It shows that in June of 2002, despite the administration's assurance that we would not have to increase the debt ceiling, the legal limit to which the United States can borrow for another 8 years, they were back a year later saying we need an increase this year of $450 billion.

Then in May of 2003 they came back and asked for an incredible amount, $984 billion. You would think that big an increase would take you at least several years. This request was approved on May 26, 2003. By the summer of 2004 the Bush administration was back, Secretary Snow came back hat in hand saying we have just about run through the $984 billion increase you allowed us last year, we need another $800 billion increase, and before we could leave for the winter break, last November, that had to be passed.

Finally this year, we had a budget resolution on the House floor, passed the Senate, has now been passed as a concurrent budget resolution. It calls for an increase of $781 billion in the year 2006.

If you add all of these debt ceiling increases together, you will see that to accommodate, to make room for the budgets of the Bush administration over the last four fiscal years, we have had to raise the debt ceiling of the United States by $3 trillion, 15 billion.

So why do we have this newfound interest in offsets? It is because the budget is becoming undeniably unsustainable.

I yield to the gentleman from Wisconsin.

Mr. KIND. Madam Speaker, I thank the gentleman for yielding to me, and